



FACT SHEET

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CMS Medicare and Medicaid EHR Incentive Programs: Stage 2 Final Rule

On August 23, 2012, the Centers for Medicare & Medicaid Services (CMS) announced a final rule to govern Stage 2 of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. The rule specifies the Stage 2 criteria that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) must meet in order to continue to participate in the EHR Incentive Programs.

Rule Provisions

Through the Stage 2 requirements of the Medicare and Medicaid EHR Incentive Programs, CMS seeks to expand the meaningful use of certified EHR technology. Certified EHR technology used in a meaningful way is one piece of a broader health information technology infrastructure needed to reform the health care system and improve health care quality, efficiency, and patient safety. Highlights of the rule's provisions follow.

Stage 2 Timing

In the Stage 1 meaningful use regulations, CMS established an original timeline that would have required Medicare providers who first demonstrated meaningful use in 2011 to meet the Stage 2 criteria in 2013. The Stage 2 rule gives providers more time to meet Stage 2 criteria. A provider that attested to Stage 1 of meaningful use in 2011 would attest to Stage 2 in 2014, instead of in 2013. Therefore, providers are not required to meet Stage 2 meaningful use before 2014. The table below illustrates the progression of meaningful use stages from the first year a Medicare provider begins participation in the program.

1 st Year	Stage of Meaningful Use										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	2	2	3	3	TBD	TBD	TBD	TBD
2012		1	1	2	2	3	3	TBD	TBD	TBD	TBD
2013			1	1	2	2	3	3	TBD	TBD	TBD
2014				1	1	2	2	3	3	TBD	TBD
2015					1	1	2	2	3	3	TBD
2016						1	1	2	2	3	3
2017							1	1	2	2	3

For 2014 only, providers that are beyond the first year of demonstrating meaningful use will have a 3-month quarter reporting period to allow an additional up to 9 months to upgrade certified EHR technology to the 2014 edition.

Meaningful Use (MU) Objectives

Nearly all of the Stage 1 core and menu objectives that were proposed are being finalized for Stage 2. The test of “exchange of key clinical information” core objective from Stage 1 is eliminated in favor of a more robust “transitions of care” core objective in Stage 2; and the “Provide patients with an electronic copy of their health information” objective is also eliminated because it was replaced by the “electronic/online access” core objective.

The final rule adds “outpatient lab reporting” to the menu for hospitals and “recording clinical notes” as a menu objective for both EPs and hospitals. There will be 20 measures for EPs (17 core and 3 of 6 menu) and 19 measures for eligible hospitals and CAHs (16 core and 3 of 6 menu).

The final rule reduces some thresholds for achieving certain measures and modifies criteria for exclusions to respond to difficulties commenters identified in implementing certain objectives in certain situations. For example, for some objectives CMS has added exclusions based on broadband availability that allow providers in rural or underserved areas to achieve meaningful use with fewer hurdles.____

- **New Core Objectives.** CMS finalized two new objectives in the core:
 - *New EP Stage 2 Core Objective:* Use secure electronic messaging to communicate with patients on relevant health information. (See “Patient Engagement” section below for additional information.)
 - *New Eligible Hospital/CAH Stage 2 Core Objective:* Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR).
- **Group Reporting.** CMS finalized the ability to use a batch reporting process for meaningful use, which will allow groups to submit attestation information for all of their individual EPs in one file.

- **Patient Engagement.** CMS proposed two new core objectives (providing patients online access to health information; secure messaging between patient and provider) with measures that require patients to take specific actions in order for a provider to achieve meaningful use and receive an EHR incentive payment. For both objectives, the threshold was set at 10 percent of patients. Many providers expressed concerns regarding this proposal. Accordingly, CMS is finalizing the proposed measures with reduced thresholds of 5 percent for both objectives. In addition, CMS is introducing exclusions based on availability of broadband in a provider’s practice area. CMS believes that the patient utilization thresholds are achievable and that the ability to access clinical information electronically promotes patient engagement.
- **Electronic Exchange of Summary of Care Documents.** To spur provider commitment to electronic exchange, CMS had initially proposed two ambitious measures for this objective in Stage 2. The first measure required that a provider send a summary of care record for more than 65 percent of transitions of care and referrals. In the final rule CMS is reducing the first measure to a lower threshold of 50 percent. The second measure required that a provider electronically transmit a summary of care for more than 10 percent of transitions of care and referrals, and that the summary of care be electronically sent to a provider with no organizational or vendor affiliation. The intent of this second measure was to foster electronic exchange outside established vendor and organization networks. CMS is finalizing the 10 percent threshold for electronic transmittal, but eliminating the organizational and vendor limitations. Instead, CMS is requiring at least one instance of exchange with a provider using EHR technology designed by a different EHR vendor or with a CMS-designated test EHR.
- **Outpatient Lab Reporting for Hospitals.** The rule includes lab reporting for hospitals as a menu objective, which gives hospitals the flexibility to select other objectives for meeting MU and receiving the incentive payment.
- **Hospital-based EP Definition.** CMS has modified the regulations on “hospital based” so that EPs who can demonstrate that they fund the acquisitions, implementation, and maintenance of CEHRT, including supporting hardware and interfaces needed for meaningful use without reimbursement from an eligible hospital or CAH—and use such CEHRT at a hospital, in lieu of using the hospital’s CEHRT—can be determined non-hospital based and receive an incentive payment. Determination will be made through an application process.

Clinical Quality Measures (CQMs)

Measure Sets and Reporting

The rule finalized that:

- EPs must report on 9 out of 64 total clinical quality measures (CQMs)
- Eligible hospitals and CAHs must report on 16 out of 29 total CQMs

In addition, all providers must select CQMs from at least 3 of the 6 key health care policy domains from the Department of Health and Human Services' National Quality Strategy:

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population and Public Health
- Efficient Use of Healthcare Resources
- Clinical Processes/Effectiveness

Data Submission

The rule finalizes that, beginning in 2014, all Medicare providers that are beyond the first year of demonstrating meaningful use must electronically report their CQM data to CMS. (Medicaid EPs and hospitals that are eligible only for the Medicaid EHR Incentive Program will report their CQM data to their state.)

EPs can electronically report CQMs either individually or as a group using the following methods:

- Physician Quality Reporting System (PQRS)—Electronic submission of samples of patient-level data. EPs can also report as group using the PQRS GPRO tool. EPs that are beyond the first year of demonstrating meaningful use who electronically report using this PQRS option will meet both their EHR Incentive Program and PQRS reporting requirements.
- CMS Portal—Electronic submission of aggregate-level data.

Eligible hospitals and CAHs will electronically report their CQMs through the EHR Reporting Pilot infrastructure for hospitals, which aligns with the Hospital Inpatient Quality Reporting program or through electronic submission of aggregate data through a CMS Portal.

Medicare Payment Adjustments

Medicare payment adjustments are required by statute to take effect in 2015 (fiscal year for eligible hospitals/calendar year for EPs). The rule finalized a process in which payment adjustment will be determined by an EHR reporting period prior to the payment adjustment year 2015. Any Medicare EP or hospital that demonstrates meaningful use in 2013 will avoid payment adjustment in 2015. Also, a Medicare provider that first demonstrates meaningful use in 2014 will avoid the penalty if they successfully register and attest to meaningful use by July 1, 2014 (eligible hospitals) or October 1, 2014 (EPs). Meaningful use attestations to State Medicaid Agencies by EPs who are eligible for either Medicare or Medicaid but opted for Medicaid, will be accepted to avoid the Medicare penalty. However, Medicaid EHR incentive payments for adopt, implement, or upgrade will not be considered having met meaningful use for those same providers (there is no payment adjustment for Medicaid payments to eligible professionals or hospitals).

Hardship Exceptions

CMS finalized four categories of exceptions for EPs: Infrastructure, New EPs, Unforeseen Circumstance, and By Specialist/Provider Type. These barriers are concentrated among three specialties: anesthesiology, radiology, and pathology. Infrastructure, Unforeseen Circumstances, and New CAHs/eligible hospitals are also exception categories for eligible hospitals and CAHs.

Hardship Exceptions by Category	
Infrastructure	Providers must demonstrate that they are in a geographic area without sufficient internet access or insurmountable barriers to obtaining infrastructure (e.g., lack of broadband or high cost build out for internet for facility).
New EPs	A limited 2-year exception for newly practicing EPs who would not have had time to become meaningful users and avoid the payment adjustments. Thus EPs who begin practice in CY 2015 would receive an exception to the penalties in CY 2015 and CY 2016, but would have to begin demonstrating meaningful use in CY 2016 to avoid the penalty in 2017.
Unforeseen Circumstances	Examples may include a natural disaster or other unforeseeable barrier. This exemption will be handled on a case-by-case basis and be very limited.
By Scope of Practice	<ul style="list-style-type: none">• Lack of face-to-face or telemedicine interaction with patients;• Lack of follow-up need with patients ; or• For EPs practicing in multiple locations: Lack of control over the availability of Certified EHR Technology at their practice location.

Medicaid Eligibility Expansion

Zero-Pay Claims

Patient volume requirements continue to be cited as a barrier to more providers participating in the Medicaid EHR Incentive Program. The rule expands the definition of what constitutes a Medicaid patient encounter, which is a required eligibility threshold.

Children's Hospitals

Under Medicaid, approximately 12 additional children's hospitals have been made eligible to participate in the EHR Incentive Program. Previously, they were unable to participate, despite meeting all other eligibility criteria, because they do not have a CMS certification number since they do not bill Medicare.

A press release on the final rule may be viewed at <http://www.hhs.gov/news> and http://www.cms.gov/apps/media/press_releases.asp.

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